



Physicians Clinic Authorization for Disclosure of Patient Information

Please provide **all** information requested or this Authorization is not valid. Please print or type.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: (____) _____ Previous Name (if applicable): _____

Patient Number: _____ (for MHS use)

I hereby authorize _____
(Facility/Provider Name and Location)

To release information from the medical record of _____
(Patient Name)

To: _____
(Name / Address of Person or Organization to which disclosure is to be made)

Fax # (____) _____ Telephone Number (____) _____

For treatment dates: _____
(Specify dates)

The following information:

- Records from last ____ year(s), including progress notes, lab and x-rays.
- Complete medical record including progress notes, lab and x-rays.
- Lab Reports date(s) _____
- X-ray Reports date(s) _____
- Progress Note date(s) _____
- Other _____

For the following purpose:

- Legal
- Insurance
- Patient request
- Other (please explain)

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby specifically authorize the release of data and information relating to: (check any that apply)

- HIV/AIDS related testing
- Mental Health
- Chemical Dependency (Drug/Alcohol)

This authorization will be valid for 180 days from the date it is signed or until _____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. MHS and its affiliates cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian

(Parent/Legal guardian must sign if patient is a minor:
NE under age 19; IA under age 18)

OFFICE USE ONLY

Copied by: _____ Date: _____

- To be sent
- To be picked up Date: _____
- Sent on Date: _____
- Picked up on Date: _____

Relationship to Patient, if not the Patient

Released by: _____

Released to: _____

Date: _____